COPD AGENTS PRIOR AUTHORIZATION FORM *(form effective 7/6/2026)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **COPD Agents** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐New request ☐Renewal request # of pages: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:		Strength:
Directions for use:	Quantity:	Duration requested:
Diagnosis:		Dx code *(required)*:

Complete all sections that apply to the member and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For a PHOSPHODIESTERASE (PDE) INHIBITOR (e.g., Daliresp, Ohtuvayre):

☐**For DALIRESP (roflumilast):**
- ☐Has COPD that is severe according to current GOLD guidelines and based on medical history, physical exam findings, and lung function tests
- ☐Has chronic bronchitis with cough and sputum production for at least 3 months per year in 2 consecutive years
- ☐Does not have moderate or severe liver impairment (Child-Pugh B or C) [contraindication]

☐**For OHTUVAYRE (ensifentrine):**
- ☐Has COPD that is moderate to severe according to current GOLD guidelines and based on medical history, physical exam findings, and lung function tests
- ☐Has a score of ≥2 on the Modified Medical Research Council (mMRC) Dyspnea Scale

☐**For ALL PDE inhibitors:**
- ☐Other causes of chronic airflow limitations have been excluded, such as asthma, bronchiectasis, heart failure, tuberculosis, etc.
- ☐Tried and failed or has a contraindication or an intolerance to first-line therapies according to current GOLD guidelines:
  - ☐Inhaled long-acting beta 2 agonist (LABA)
  - ☐Inhaled long-acting anticholinergic/muscarinic antagonist (LAMA)
  - ☐Inhaled corticosteroid (unless member has an eosinophil count <100 cells/microliter – *submit documentation of lab results*)
  - ☐other:

_____

☐ Does not have suicidal ideations

☐ **For a member with a history of suicide attempt(s), bipolar disorder, major depressive disorder, schizophrenia, substance use disorder(s), anxiety disorder(s), borderline personality disorder, and/or antisocial personality disorder:**
- ☐ Was evaluated and treated for this/these mental health condition(s) by a psychiatrist
- ☐ Is a candidate for treatment with the requested PDE inhibitor as determined by a psychiatrist

☐ **For a member who does not have a history of the above mental health conditions:**
- ☐ Had a mental health evaluation performed by the prescriber
- ☐ Is a candidate for treatment with the requested PDE inhibitor

2. For all OTHER COPD Agents:

☐ Tried and failed or has a contraindication or an intolerance to the preferred COPD Agents (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

RENEWAL requests

1. For a PHOSPHODIESTERASE (PDE) INHIBITOR (e.g., Daliresp, Ohtuvayre):

☐ **For DALIRESP (roflumilast):**
- ☐ Frequency of COPD exacerbations has decreased since starting Daliresp
- ☐ Does not have moderate or severe liver impairment (Child-Pugh B or C) [contraindication]

☐ **For OHTUVAYRE (ensifentrine):**
- ☐ Experienced a positive clinical response to Ohtuvayre as documented by:
  - ☐ Increased pulmonary function
  - ☐ Decreased dyspnea severity
  - ☐ Decreased use of rescue drugs
  - ☐ Decreased symptom severity

☐ **For ALL PDE inhibitors:**
- ☐ Does not have suicidal ideations
- ☐ Was evaluated for new onset or worsening symptoms of anxiety and depression
- ☐ Is a candidate for treatment with the requested PDE inhibitor

2. For all OTHER COPD Agents → complete member, prescriber, and drug fields at the top of this form and submit request with recent chart notes to PA Health & Wellness

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)